TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH DBA INJURY 1-DALLAS

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-16-1019-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT Code 90837 was preauthorized, #10936XXX therefore it is deemed medically necessary."

Amount in Dispute: $1,451.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider argues that there was preauthorization BUT the certification start date was 2/12/15 AFTER the 2/9/15 DOS. The 2/9/15 DOS required preauth but that was not obtained so there should be no reimbursement for that DOS. The provider waived its right to reimbursement for that DOS."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 9, 2015 through April 13, 2015	90791 and 90837 x 2	$1,451.30	$399.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
4. 28 Texas Administrative Code §134.203 sets out the Medical Fee Guideline for Professional Services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50- These are non-covered services because this is not deemed a 'medical necessity' by the payer

Issues

1. Does the medical fee dispute referenced above contain information/documentation to support that date of service February 9, 2015 contains unresolved issues of medical necessity?
2. Did the requestor submit documentation to support that CPT Code 90837 rendered on April 7, 2015 and April 13, 2015 were preauthorized?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds that the medical fee dispute referenced above contains information/documentation to support that there are **unresolved** issues of medical necessity for date of service February 9, 2015. The insurance carrier denied CPT Code 90791 with denial reason(s) code "50- These are non-covered services because this is not deemed a 'medical necessity' by the payer."

   The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

   The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

   The division finds that due to the unresolved medical necessity issues for date of service February 9, 2015 is not eligible for review, until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

2. The insurance carrier denied disputed dates of service April 7, 2015 and April 13, 2015, with claim adjustment reason code "50- These are non-covered services because this is not deemed a 'medical necessity' by the payer." Review of the submitted preauthorization letter dated, February 16, 2015 finds the following:

Requested Service Description	Psycho Therapy 1x Wk x 4 Wks
Certified Quantity	4 Cognitive Therapy
Start Date	02/12/15
End Date	05/29/15
Requesting Provider	Michael Lopez

   28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program..." The requestor obtained preauthorized for 4 cognitive therapy services. Review of the CMS-1500 documents that the requestor billed CPT Code 90837. The AMA CPT Code book defines CPT Code 90837 as "Psychotherapy, 60 minutes with patient and/or family member."

Per 28 Texas Administrative Code §134.600 "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (1) listed in subsection (p) or (q) of this section only when the following situations occur." The Division finds that the insurance carrier preauthorized the disputed service rendered on April 7, 2015 and April 13, 2015. As a result, the insurance carrier's denial is not supported. The disputed services are therefore reviewed per the applicable Division rules and fee guidelines.

3. Per 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   The MAR reimbursement for CPT Code 90837 is $199.51 x 2 = $399.02. The Requestor seeks $199.50 x 2 = $399.00, therefore this amount is recommended. The Division finds that the requestor is entitled to reimbursement in the amount of $399.00 for CPT Code 90837 rendered on April 7, 2015 and April 13, 2015. As a result, $399.00 is recommended to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $399.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $399.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January 14, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.